Restorative HEALTH

AESTHETIC INTAKE

Patient Name:_____ Date:_____

Date of Birth:_____ Age:_____ Sex:_____ Ht:_____ Wt:_____

Address: _____City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone:_____

Email:_____

In case of emergency, notify (name/phone number): _____

How did you hear about us (internet/social media/friend (list name)?:_____

Are you currently using or taking (check all that apply):

□ Adipex (Phentermine)
□ Antibiotics in the past 2 weeks
□ Any acne medications or Vitamin A derivatives
□ Beta or Alpha Hydroxy Acids (AHA BHA)
□ Contraceptives (Oral, Implantable, IUD's, Other)
□ Diethylpropion
□ Glycolic Acids
□ HCG
□ Hormone Replacement
□ Hydrocortisone _____%
□ Hydroquinone
□ Indoor/Outdoor Tanning or Sunburn in the past 2 weeks
□ Isotretinoin/Accutane in the past 6 months
□ Oral Antibiotics
□ Retin-A_____% Renova _____% Differin
□ Retinols in skin care
□ Scrubs or Peels
□ Smoker

Health information (check all that apply):

□ Acutane
□ Anemia
□ Anorexia
□ Asthma
□ Autoimmune disorders
  □ Lupus
  □ CREST
  □ Scleroderma
  □ Hashimoto's
  □ Multiple Sclerosis
  □ Rheumatoid Arthritis
  □ Other
□ Bell's Palsy
□ Bleeding Disorder
□ Body Piercing
□ Breast Feeding
□ Breast Lump
□ Bruising
□ Cancer treatments
□ Chemical Dependency
□ Chronic Fatigue
□ Claustrophobia
□ Cold Sores/Fever Blister
□ Contact Lenses
□ Currently pregnant
□ Diabetes
□ Eczema
□ Epilepsy
□ Eye Disorder
□ Fibromyalgia
□ Heart problems
□ Hepatitis A,B or C
□ Herpes virus
□ High/Low Blood Pressure
□ HIV / AIDS
□ Hyper/Hypothyroid
□ Keloid Scarring
□ Lambert-Eaton Syndrome
□ Menopause
□ Metal implants
□ Myasthenia Gravis
□ Pacemaker
□ Parkinson's
□ Poly Cystic Ovarian Disease
□ Psoriasis
□ Rosacea
□ Scarring
□ Seizures
□ Skin Cancer
□ Staph/MRSA
□ Stroke
□ Warts

Are you currently undergoing chemotherapy or radiation therapy? □ Yes □ No

Are you currently pregnant? □ Yes □ No If Yes, due date: _____ If No, are you trying to get pregnant? □ Yes □ No

How many hours do you normally sleep at night?_____ Do you snore? □ Yes □ No

Type of diet: □ Standard American Diet □ Paleo □ Plant Based □ Vegetarian □ Vegan □ Other:_____

What are you currently doing for exercise?_____

Current Prescription Medication, Over the Counter Medication and Supplements			
Name of Medication / Supplement	Reason for Taking	Strength	Dosing Instruction
Example: Tylenol	Headaches	500mg	1 tab 3 times per day

Allergies to medicine, supplements, vaccines, foods, environmental or other substances	
Substance	Reaction
Example: Penicillin	Hives, Swelling, Shortness of Breath

Are you currently taking Aspirin, Ibuprofen or other anti-inflammatories? □ Yes □ No

Do you have allergies or sensitivities to (check all that apply):

□ Any Botulinum toxin (Botox)
□ Apples/Citrus/Grapes
□ Cosmetics
□ Essential Oils
□ Fragrances
□ Hydroquinone
□ Latex
□ Lidocain/Novocaine
□ Milk/Dairy
□ Nuts
□ Skin Care Ingredients

Are you under the care of a physician or Dermatologist? □ Yes □ No

Please indicate which treatments you have had:

□ Cellulite / Fat Loss
□ Dermal HA Fillers: e.g. Juvaderm
□ Electrolysis
□ Fillers: Sculptra, Artefill, Collagen
□ Laser Hair Removal
□ Laser Skin Resurfacing
□ Laser Skin Tightening
□ Laser Vein
□ Microneedling
□ Neurtotoxis: Botox/Dysport
□ Peels/Microderm/Facials
□ PhotoFacial IPL
□ PRP Hand, Scalp, Scar
□ Vampire Breastlift
□ Vampire Facelift
□ Vampire Facial
□ Waxing

Adverse reactions to any of the above? □ Yes □ No If yes, please explain:_____

_____

Were you pleased with your results? □ Yes □ No Please explain:_____

_____

Have you ever had any cosmetic surgery? □ Yes □ No

Procedure:_____ Date:_____

Procedure:_____ Date:_____

Procedure:_____ Date:_____

Have you received Botox/Dysport or fillers such as Juvederm/Restylane treatments in the last 14 days? □Yes □No

Have you received a chemical peel, microdermabrasion, IPL, laser or other resurfacing treatment in the past month? □Yes □No

Do you have Permanent Cosmetics? If yes, where?: _____

Have you or anyone in your family ever had skin cancer? □ Yes □ No

Question	Frequently	Occasionally	Rarely or Never
How often do you use a tanning bed?			
How often do you use self-tanning lotions or self-tanning treatments?			
How often are you exposed to the sun, whether during work or at play?			
Do you burn from sun exposure?			
How often do you wear sunblock			

Skin Type:

I. What is the natural color of your eyes?

0 Light blue, Gray, Green
1 Blue, gray, green
2 Blue
3 Dark Brown
4 Brownish Black

What is the natural color of your hair?

0 Sandy Red
1 Blond
2 Chestnut/Dark Blond
3 Dark Brown
4 Black

What is the color of your skin (in non-sun exposed areas)?

0 Reddish
1 Very Pale
2 Pale with beige tint
3 Light Brown
4 Dark Brown

Do you have freckles?

0 Many
1 Several
2 Few
3 Incidental
4 None

Score:_____

II. What happens if you stay in the sun too long?

0 Painful redness, blistering and peeling
1 Blistering followed by peeling
2 Burn sometimes followed by peeling
3 Rarely Burns
4 Never Burns

To what degree do you turn brown?

0 Hardly or not at all
1 Light color tan
2 Reasonable tan
3 Tan very easy
4 Turn dark brown quickly

Do you turn brown within several hours after sun exposure?

0 Never
1 Seldom
2 Sometimes
3 Often
4 Always

How does your face react to the sun?

0 Very Sensitive
1 Sensitive
2 Normal
3 Very Resistant
4 Never had a problem

Score:_____

Skin Type Score	Fitzpatrick Skin Type
0 - 7	I
8 - 16	II
17 - 25	III
25 - 30	IV
30+	V-VI

What is your skin tone? □ Very Fair □ Medium □ Dark □ Fair □ Medium-Olive □ Very Dark

What do you believe best describes your skin type? (check all that apply): □ Dry □ Normal/Combination □ Oily □ Sensitive □Aging □ Acne □ Severe Acne

What are your skin concerns? (check all that apply):

□ Acne /Breakouts
□ Age Prevention/Healthy Skin
□ Blackheads/ Clogged Pores
□ Blood Capillaries
□ Crows Feet
□ Excessively Dry /Dehydrated
□ Excessively Oily
□ Fine Lines/Wrinkles
□ Freckles
□ Hyperpigmentation (brown spots,
□ Large Pore Size
□ Redness/Sensitivity
□ Rosacea
□ Skin Laxity
□ Skin Tags
□ Spider Veins
□ Stretchmarks
□ Sun Damage
□ Under Eye Puffy/Dark Circles
□ Uneven Skin Tone
age spots)

Other:_____

_____

_____

When it comes to caring for your skin at home, which statement best describes you? (check one):

□ I barely use anything on my skin
□ I use a cleanser and moisturizer
□ I use cleanser, toner and moisturizer and occasionally will add in an extra product or two (For example - mask, serum, scrub , peel or eye cream)
□ I use a full routine, complete with serums, masks and eye cream

Describe your current skin care routine. Please list brand:

Daytime **Evening**

Cleanser:_____ Cleanser:_____

Scrub:_____ Scrub:_____

Toner:_____ Toner:_____

Moisturizer:_____ Moisturizer:_____

Serums/Other:_____ Serums/Other:_____

What are your goals for your skin?: _____

_____

_____

_____

Is there anything else we need to know about you in order to better service your needs?: _____

_____

_____

_____

_____

Thank you for taking the time to complete this client intake form. All of the information above is extremely helpful to ensure the best care for you and ensure your safety during treatment. Read and initial the below:

- Please note: An aesthetic procedure may cause the skin to purge resulting in a break out. This is normal and does not mean you are having a reaction to the products. If you experience any itching, burning, or rash following your facial treatment please notify your skin care professional immediately so they may advise you or find a different product for your skin. (initial) ____

- I am aware that certain medications and over-the-counter products can significantly increase the risk of injury when combined with skin care services. (initial) _____

- I understand I may carry Herpes and/or Staph/MRSA without any physical symptoms or a medical diagnosis. I also understand that the facial service does not allow the opportunity to contract these conditions from my technician. (initial) _____

- I understand all of the above mentioned reactions. I also understand if I change my skin care routine or medications, or my health condition changes, I must inform the professional PRIOR to any service in the future. (initial) _____

- I understand that there are often inherent risks associated with skin care services, and I agree that as a condition of providing these services on an ongoing basis, I will not hold this salon/service provider liable. (initial) ____

- I have signed the procedure consent form. (initial) _____

Patient Signature: : _____ Date: _____